Client's Name: _____ Client ID#: _____

Consent for Treatment, Limited Confidentiality & Waiver Regarding Services provided by Office of Juvenile Justice by

_____ (therapist)

1. I/We acknowledge that the minor child_____, under my legal guardianship has been referred for services under the terms of his/her Probation Agreement and that the nature of the services provided will be mutually determined by myself and the probation officer and may include individual, group or family counseling.

2. I/We understand the nature of counseling services and that such services involve both benefits and risks. Since at times counseling involves discussing unpleasant experiences or aspects of life, the participant may experience uncomfortable feelings like sadness, guilt, anger and frustration. I/We also understand that counseling services have also been shown to have many benefits. It often leads to solutions to specific problems, better relationships, positive behaviors, better decisions and eventual reductions in feelings of distress. In order for counseling services to be effective it is necessary that the guardian and the youth play active roles. Participation involves discussing concerns openly, completing assignments and providing feedback to the counselor about progress.

3. I/We consent to the treatment which may be recommended by the therapist and understand that such treatment may include assessment, diagnosis, individual and family counseling. This consent for treatment expires 365 days following it's authorization but may be revoked in writing at anytime.

4. I/We understand that such treatment is being recommended and provided by agreement with the Office of Juvenile Justice and that I/we will not be billed for treatment directly but my/our full participation is expected. I/We understand that noncompliance or failure to notify in event of cancellation may result in agency action or termination of services.

5. I/We consent to this treatment by therapist and acknowledge receipt of the professional disclosure statement. The therapist may provide direct social work practice, including psychotherapy (individual, family and group therapy).

6. In regards to assessment, treatment planning and individualized intervention, I/we consent to diagnosis and intervention plans with the cooperation and consultation of and with the Office of Juvenile Justice, its representatives as well as other state agencies or court jurisdictions as they apply directly to my/our case.

7. The therapist may release the following specific information: Social History, Biopsychosocial Assessment, Progress Note, Face Sheet, Treatment Plan or verbal report, to the Office of Juvenile Justice, Department of Children and Family Services and/or if necessary a local emergency room, medical health care provider, OYD/DCFS representative, coroner, physician, jurisdictional judge/court) or other agent in the event of a medical or psychiatric emergency.

8. I/We understand that in most cases the counselor/therapist can only release information about the treatment to others if I/we sign written authorization. However, my/our signature on this agreement provides written advanced consent for the following:

a. Provision of information to the court regarding the quality of participation in services. This will not include details of what was discussed in counseling sessions.
b. Communication between counselor/therapist and the youth's probation officer that is necessary for each to effectively perform their responsibilities or duties.
c. Provision for Assessment and Service Plan information to other OYD/OJJ contracted providers who are/will be providing services to the youth.

9. I/We understand that there are some situations where the counselor/therapist is permitted or even required to disclose information without either your consent or written authorization. As a mental health professional, the therapist is a mandated reporter of alleged or suspected child, disabled or elder abuse and neglect and that he is legally and ethically obligated to report such in addition to acute suicidal or homicidal risk to the appropriate authorities. The foregoing is an exception to any and all expectations of confidentiality.

10. I/We understand that the therapist , although he or she may access and assist in crisis situations, but is not to be expected to provide emergency services for such risks of intent to harm self or others. Any emergencies should result in call to 911 or emergency services.

I/We acknowledge that I/we have read, or had explained to me the information described above and I/we consent to the provision of counseling services to the minor child and/or family by a clinically licensed/supervised staff member of the Office of Juvenile Justice. I understand that I may revoke this consent in writing at any time.

X	(mm/dd/yyyy)
Signature of Client or Guardian if under 18	**Date of Signature**
X	(mm/dd/yyyy)
Signature of Youth	**Date of Signature**
X	(mm/dd/yyyy)
Signature of Therapist	**Date of Signature**